# Department of Early Learning NRMT Meeting Notes

*June 21, 2008, Ellensburg, Washington*

The following agenda guided our discussion.

***Overall Goal:***

The purpose of this Negotiated Rule Making Team (NRMT) is to develop a set of rules and recommendations about issues that affect the health, safety, learning and quality of environment for children that is supported by parents, early care providers, health/ safety experts and interested stakeholders. The NRMT's proposed rules will then move on to the legal and legislative proceedings (and formal public comment period) before they can be formally adopted.

***Today's Meeting Objectives:***

- Hear from Public Health representatives about issues pertinent to ***Licensing Process Environments*** and ***Infant Care***;
- Continue our discussion and hear recommendations about ***Licensing Process***;
- Discuss and determine what elements should be incorporated into our work moving forward; and
- Determine next steps.

***Pre-Work Given at May 17, 2008 Meeting:***

- The Team C (Martha Standley is Lead) will continue their work on ***Licensing Process***, working specifically on:
  - Types of licenses;
  - Recommendations for a Renewal process and rule; and
  - Exemptions
- The A-Team (Debbie Knighten is Lead) will continue work on the topic of ***Infant Care***.
- The West Side Story (Karen Hart is Lead) will continue work on the topic of ***Programs***.

| ***Time*** | *Topic* |
|---|---|
| **10:00** | Welcome, Agenda Review, Check in |
| **10:20** | Update<br>♦ NRMT Roster (Protocols)<br>♦ Rule Writing |
| **10:30** | Visit from Public Health Professionals |
| **11:40** | Break for Lunch |
| **12:00** | Resume Public Health Presentation/ Discussion |
| **12:50** | Break |
| **1:00** | Work Group Meetings |

| | |
|---|---|
| **1:20** | Recommendations about ***Licensing Process*** – Team C |
| **3:15** | Next Meeting Agenda (August 9, 2008), Assignments, Project Schedule Adjustments. |
| **3:30** | Adjourn |

## *Voting Members Present:*

Blanca Smith – DEL
Lydia DeLeon – DEL
Corina Villarreal – Provider
Debbie Knighten – Provider/SEIU
Laura Dallison – DEL
Jean Orton-Elders – DEL
Martha Standley – DEL
Judy Bunkelman – DEL
Mary Kay Quinlan – DEL
Angela Taylor – Provider/SEIU
Cassandra Clemans - Provider Advocate
Sue Winn, - WSFCCA
Donna Horne -WSFCCA
Sylvia Mierau -Provider/SEIU
Sue Paskiewitz – Provider/SEIU
Lisa Beaulaurier – SEIU
Katherine Yasi – Provider/SEIU
Judy Jaramillo – DEL
Lola Kling – Provider SEIU

**Alternates, Public, Guests and Others**

Kathleen Hardee – Provider Advocate Alternate
Micha Horn, Snohomish County Health District
Nicole DeFrank, Snohomish County Health District
Elaine Ruhlman RN, Benton-Franklin Health District

Debbie Rough-Mack, Facilitator
Andy Fernando, DEL NRMT Coordinator

## *Welcome, Check in*

We welcomed new NRMT member Jean Orton-Elders, a licensor in the Tumwater DEL office. Jean is on the Southwest Team-C and has been attending those subgroup meetings already.

## ***NRMT Protocol Update***

NRMT Coordinator Andy Fernando reported that there is one remaining NRMT member who has not returned the signed protocol agreement that all members unanimously agreed to at the March 2008 meeting. Andy received a note from the member yesterday expressing concern that limitations on any member communicating with the media may infringe on first amendment (free speech) rights. Andy indicated that DEL legal staff is reviewing the protocols and will advise before the August 9 meeting if revisions may be needed. He will keep the group informed as to what he learns.

Andy also reported that DEL Management has directed that future NRMT meetings will be recorded – either by a "court reporter" or by video tape - to ensure accurate representation of the

context and intent of the group's discussion. All tapes or transcripts associated with the meetings will be part of the public record.

## ***Update from Rule Writers***

Judy Jaramillo shared a "Rule Format Comparison Matrix," that she, Sandra Van Doren and Andy Fernando created to illustrate what three different rule formats might look like (Question & Answer, Outline and Narrative styles). They used the NRMT matrix on Food to create an example of how the same requirement could be written in the three different formats. Judy said that all three of the rule writers felt that the matrix made it relatively easy to write clear rules that represented the group's intent.

The group discussed the merits of each style. Judy and Sandra were surprised that they liked the question & answer format as well as they did. Judy said she believed the rule writing training helped them to know how to write clearer rules in each different format. Several providers and licensors mentioned that the current Q & A format of the family home WAC is so widely disliked that a total change from the Q & A format may be necessary in order for providers and licensors to feel acknowledged in their complaints about this format. It was suggested that the Provider Guidebook could be written in Q&A or Narrative format. Though the vote below indicates the preference identified by members, ***all members indicated that they could support the NRMT's recommended rules be written in Outline format.***

***Question & Answer*** – 1 vote
***Outline*** – 14 votes
***Narrative*** – 1 vote

Team members expressed appreciation to the Rule Writing Team for the sample to illustrate the differences. They will begin writing draft rules for the rest of the Food and Nutrition, Staff Qualifications, and Licensing Process topics.

### *Clear Rule Writing Class*

Andy said that there will be a Clear Rule Writing training class (the same as Judy and Sandra attended in April), this time sponsored by DEL on August 20 & 21, 2008, in Lacey. The class is taught by a nationally-known "plain talk" specialist from Maryland, Ginny Redish. Several spots in the class are reserved for NRMT members and other DEL staff who are working on other rules. If members would like to attend, let Andy know. DEL is paying the tuition cost for people attending the class, but would not be covering travel expenses.

## ***Visiting Local Public Health Professionals***

We welcomed three local public health care professionals who came to address the health and safety questions that we submitted and to inform our rule recommendations in the categories of ***Licensing Process, Environments***, and ***Infant Care***:

- Nicole DeFrank, Environmental Health Specialist, Snohomish County Health District, spoke to us about safe septic systems for home child care that are not on a public sewer.

- Micha Horn, Environmental Health Specialist, also from the Snohomish County Health District, spoke to us about safe drinking water.
- Elaine Ruhlman RN, Child Care Health Specialist with the Benton-Franklin Health District, spoke to us about infant care and feeding.

Nicole, Micha and Elaine were responding to a list of questions (attached) on septic systems, water, infant care and other issues submitted by NRMT members. Nicole and Micha used a PowerPoint slide show for their presentations, and Elaine used a handout.

There also were available handouts on septic, water, infant feeding and sanitizers provided by the local public health specialists and from several DEL Health Specialist for child care centers who also responded to the NRMT members' questions. *Text materials used or available at the June 21 NRMT meeting are attached to these notes, starting on page 7. The PowerPoint presentation is available at the Negotiated Rule Making page on the DEL website, at http://www.del.wa.gov/laws/rules/negotiated.aspx.*

On septic systems and drinking water, Nicole and Micha described the statewide requirements adopted by the Department of Health, and how various public health districts apply the requirements differently at the local level. Nicole described how private septic system capacity for child care is determined, how systems are designed and function, how to determine if a system is failing, and recommended inspection and maintenance. Micha described various types of private water supply methods, small and large public water systems, and recommended water tests for bacteria, certain chemicals and lead. She noted that there is no statewide requirement to test private single family wells, although some health districts are designating home child care businesses with private wells as "Class B" water systems that must be tested annually for coliform bacteria (e-coli). Nicole and Micha also described how public health septic inspections and water testing are handled differently from county to county, including examples of costs.

Elaine provided current recommended practice on infant feeding, sleeping, care and prevention of Sudden Infant Death Syndrome (SIDS). She noted how the practice of laying infants to sleep on their backs appears to be related to the significantly reduced SIDS deaths in Washington State since the 1990s. Nicole, Micha and Elaine also offered some suggestions for the rules on septic inspection, water testing and infant care. Discussion was spirited and NRMT members had many questions, more than our meeting time allowed. We were unable to cover questions on bleach and alternative sanitizers, which was of interest to several NRMT members.

## ***Licensing Process – Team-C***

What follows are the highlights and decisions resulting from the discussion. For more complete information refer to the handouts from the meeting.

### ***Subtopic: Child Care Subsidies, Presenter: Martha Standley***

Team-C group recommended that the Subsidies topic be left out of family home WAC, based on recommendation from Andy Fernando and Judy Jaramillo. Martha said the group didn't think calling out specific subsidies should be identified in WAC, since there are many from federal, state, county and private sources of child care subsidies; rather they should be described in the guidebook. (Also, it may already be covered by requiring compliance with other applicable

requirements in the "Compliance with Other State laws and Rules and City and County Ordinances section.)
***Vote 14 in favor, 5 undecided, 0 opposed***

There was concern expressed by some of the undecided members that we need to cover compliance with DEL child care subsidy rules in the family home rules.

***Subtopic: Application Profess Licensing the Facility, Certifying the Provider, Staff and Volunteers, Presenter: Martha Standley***
Based upon the large group's recommendation from Team C to pursue how to separate the certification of the provider(s) from the licensing of the facilities, a position paper has been prepared by Andy and formally submitted to DEL with that recommendation. However, the group did not want any recommended WAC's to be dependent upon the outcome of that decision, so they will continue with WAC recommendations that are independent of that issue.

***Subtopic: Types of Licenses, Presenter: Angela Taylor***
***I. Initial License***
The group voted that an Initial License will be issued when all health & safety requirements are met but the provider, because she or he has yet to begin taking children into care, cannot demonstrate full compliance with all WAC, such as observed interactions with children, required record keeping, etc. This is the same concept as the current requirement.
***Vote 19 in favor, 0 undecided, 0 opposed***

***II. Full License***
The group voted to recommend the following, similar to the current rule:
"(1) We (DEL) must issue a full license to you when you can demonstrate compliance with all rules contained in this chapter at any time that you have an initial license.

(2) We must not issue a full license to you if you do not demonstrate the ability to comply with all rules contained in this chapter during the period you have an initial license.

[*And new added language*] (3) A full license must be received by licensee within 90 days after demonstrating the ability to comply with all rules contained in this chapter.

***Vote 19 in favor, 0 undecided, 0 opposed***

***III. Probationary License***
The group voted to include the language in WAC 170-296-0440, with an added subsection:
"(8) You have the right to refuse a probationary license. If the probationary license is refused by you, you risk adverse licensing action such as modification, denial or revocation of your license."

***Vote 17 in favor, 2 undecided, 0 opposed***
The group noted that the Guidebook should include an explanation of probationary license process. The rule should include definitions of different licensing types. This topic generated a lot of discussion, and may be revisited.

***IV. Multiple Licenses for Caregiving of Children (Dual Licenses)***
The group voted to recommend the following five items recommended by Team-C:
1. Change sub-topic name from "Dual Licenses" to "Multiple Licenses for Caregiving of Children"

2. Add to the application process (could even just be on application) that applicants need to inform DEL that they have another license or are in application process for another caregiving license [such as foster care, adult family home, etc.].

3. Remove most of WAC 170-296-0280

4. Add: The licensor may require an approved, written plan (to be approved by the licensor) for how the licensee will manage the caregiving needs of children in child care with multiple licenses. If plan approval cannot be resolved, the provider may give up the license or DEL may suspend, deny or revoke the child care license.

5. Add to 'circumstance changes' that the licensee must inform DEL if they are applying for another caregiving license and provide a written, approved plan for providing care under multiple licenses.

***In a single vote on all five items, Vote: 15 in favor, 4 undecided, 0 opposed***

## ***Next Steps, Action Items***

- The group voted that the next meeting will be an overnighter in Kent or Seattle on August 8 and 9. Small groups will arrange their own Friday meeting times and the large group will meet on Saturday. Andy will be sending out location details and lodging suggestions.

- For August 9, Andy will have recommendations from DEL legal counsel about the NRMT Protocol, and will have either a transcriptionist or video recorder and operator to record the meeting discussions.

- Debbie Knighten will coordinate with Andy to arrange for an presentation from a DEL supervisor who is a specialist in outdoor environments for the September 20, 2008, meeting.

- Andy has drafted a preliminary "big-picture" project timeline into 2009, which he made available to the group. At our next meeting we will discuss if we want to make adjustments to the meeting schedule or timelines.

## ***Pre-Work for the Small Groups:***

- Team-C (Martha Standley is Lead) will incorporate the expert recommendations relevant to ***Licensing Process*** topics, which we will finish up next time, working specifically on:
    - Recommendations for a License Renewal process; and
    - Exemptions from Licensing.

- The A-Team (Debbie Knighten is Lead) will incorporate the expert recommendations relevant to ***Infant Care***, which they will present at the August meeting  After that, they will begin work on the topic of ***Environments***.

- The West Side Story (Karen Hart is Lead) will continue work on the topic of ***Program***.

# Attachments from June 21, 2008 NRMT: Handouts on Septic Systems, Safe Drinking Water, Infant Care, TB Testing, and Sanitizers (Bleach and Bleach Alternatives)

1. Public Health Questions (posed by NRMT members) for June 21, 2008, DEL Negotiated Rule Making Discussion with Local Public Health Representatives

2. *Regulatory Oversight of On-site Septic Systems for Washington State Child Care Programs Briefing Paper,* Authored by the Washington State Child Health and Safety Advisory Committee, July 1, 2007

3. *Regulatory Oversight of Well Water for Washington State Child Care Programs Briefing Paper,* Authored by the Washington State Child Health and Safety Advisory Committee, July 1, 2007

4. Notes on: Infant Feeding and Care. Elaine Ruhlman, Child Care Health Specialist, Benton-Franklin Public Health

5. "*Prevent Choking in Children*" brochure. Benton-Franklin Health District

6. Notes on NRMT questions on septic, water, infants, sanitizers and TB. Kathryn Quinn, DEL Health Specialist – Eastern Service Area

7. Notes on NRMT questions on septic, water, infants, sanitizers and TB. Hazel Philp, DEL Health Specialist – Northwest Service Area

8. Excerpts from Caring for our Children, 2nd Edition regarding TB testing and Infant feeding

9. *Infant and Toddler Feeding*. Seattle-King County CCHP Health Policy Templates

10. [State of Colorado] *GUIDELINES FOR THE USE OF SANITIZERS AND DISINFECTANTS IN CHILD CARE CENTERS*, not dated.

11. Notes on NRMT questions on septic, water, infants, sanitizers and TB. Mark Kastenbaum, DEL Health Specialist – Southwest Service Area

12. Additional materials responding to NRMT questions: See the attached Adobe file: "AdditionalHealthMaterialsReNRMTQuestions.pdf"

    a. Storing breast milk (information advertisement from the Women, Infants and Children [WIC] nutrition program)

    b. Heating formula (June 20, 2008 e-mail from Mead Johnson Nutritional to Elaine Ruhlman RN)

    c. *A Child Care Provider's Guide to Safe Slee*p (from the American Academy of Pediatrics, undated)

d. Are BPA plastic's claims shatterproof? (Seattle Times article, May 19, 2008 regarding plastic contains containing bisphenol A plastic)

Not attached but available on request to the DEL NRMT Coordinator:

- *Understanding and Caring for Your Septic Tank System* - brochure. Washington State Department of Health, Washington State University Cooperative Extension, 1996.

- *Home Based Child Care Septic Systems* – brochure. Snohomish Health District, 2005.

- *Family Home Child Care Individual Wells and Small Public Water Systems* – brochure. Snohomish Health District, 2005.

- *Safe Sleep for Your Baby – Reduce the Risk of Sudden Infant Death Syndrome (SIDS)* – brochure. U.S. Department of Health and Human Services, 2005.

- *Septic Systems for Child Care – Well Water and Child Cares*. PowerPoint presentation (29 slides). Nicole DeFrank, MS, REHS; and Michaela Horn, MS, RS – Snohomish Health District, 2008. *This slide presentation will be available on the Department of Early Learning Negotiated Rule Making website at* http://www.del.wa.gov/laws/rules/negotiated.aspx.

# 1.

Public Health Questions (posed by NRMT members) for
June 21, 2008 DEL Negotiated Rule Making
Discussion with Local Public Health Representatives

The Department of Early Learning (DEL) is engaged in 'negotiated rule making" to revise the licensing rules for Family Home Child Care in chapter 170-296 WAC. The Department has formed a Negotiated Rule Making Team (NRMT) comprised of child care providers, parent and provider advocates, the child care resource and referral network, Service Employees International Union, and DEL staff to gather information and recommend content for the revised rules.

From time to time, the NRMT plans to ask various subject matter experts to help the group understand current federal, state or local requirements related to providing child care, best-practices, or other information that would help promote a safe and healthy child care environment in DEL-licensed family homes.

1. SEPTIC SYTEMS

   a. What are the statewide laws and rules regarding single-family residential septic systems?

   b. Are the septic system laws and rules applied the same way statewide, or are there differences from one local health jurisdiction to another (please explain if the latter)?

   c. How is single-family septic system capacity determined? How does running a family home child care affect this capacity?

   d. How often should a septic system be checked? Does this vary depending on the type of system? Can the homeowner check the system, or does this need to be done by public health? What are typical costs of checking the system?

   e. What are the health risks if a septic system isn't working properly? Are there ways to tell – other than sight or smell – if the system isn't working or may be failing?

   f. Are there things the owner can do in their child care operation to help prevent septic problems?

2. WATER

   a. What are the statewide laws and rules regarding well water? Are they different if you are on a private well compared to a small community system (such as a water association)?

   b. Are the well water laws and rules applied the same way statewide, or are there differences from one health jurisdiction to another (please explain if the latter)?

c. What are the main health concerns about well water? Are there concerns other than for drinking?

d. How often must a private well be inspected and/or tested? If not required, how often should the family home child care provider have the well inspected or tested?

e. What is considered an "acceptable" well water test? Who does the testing, and what does the test look for? How much does a water test costs typically?

f. If a family child care home uses bottled water for drinking/cooking, are there still concerns about using private well water for other uses?

g. Do water filters affect the fluoride content in water from a water system that adds fluoride? If yes, what can the child care provider do to replace the fluoride in the water?

3. SANITIZING

a. **Bleach**. Are there any health risks of residues or fumes from using bleach sanitizing solutions around children? If there may be risks, what are ways to reduce the risks?

b. **Bleach Alternatives**.

i. Are there products that are acceptable alternatives to bleach? Are the alternative products safe to use around children and in food preparation/serving areas?

ii. Lysol brand markets professional products as part of 'child care hygiene program." Are there any health or safety concerns about using these products around young children?

c. **Sanitizing surfaces**.

i. When changing diapers, is there a benefit to washing the child's hands if the child didn't touch the diaper area?

ii. If disposal changing pads are used, is it necessary to sanitize the changing area?

iii. What is the best way to sanitize toys and other items that children have had (or will likely have) in their mouths? Do sanitizing solutions affect the materials in toys, and is this a concern?

3. INFANT CARE

a. Are there any state laws or rules regarding infant feeding? If no, what are considered "best practices" for infant feeding?

b. What are the recommended practice for storing and serving breast milk?

c. How should water be heated for making baby formula? Would using a "tankless" instant hot water system make any difference in how formula should be prepared?

d. Besides not heating foods in plastic containers, are there any other concerns about storing or serving foods in plastic containers?

e. What is the current recommended infant sleeping practice to help prevent SIDS?

f. Do have other best practice guidance about infant feeding, sleeping or other infant care?

4. TB TESTS FOR CHILD CARE STAFF

What is the most current TB testing regimen, and how does it compare with the requirement in DEL WAC 170-296-0160(2)(b), which is: "*(b) Documentation of a negative Mantoux tuberculin (TB) test in the twelve months prior to starting work for you, staff, volunteers and members of the household sixteen years or older*;"…

**2.**

# Regulatory Oversight of On-site Septic Systems for Washington State Child Care Programs Briefing Paper

**Authored by the Washington State Child Health and Safety Advisory Committee**

**July 1, 2007**

## Scope

A majority of the septic systems currently serving child cares were not designed for that particular purpose and thus have an increased risk of failing. Failing systems are an imminent public health hazard. Large water flows from handwashing, toileting, food preparation, general sanitation, laundry, and water play can easily exceed the design capacity of a residential septic system. Some septic systems are old and do not meet the current design standards, further increasing the risk of failure.

Washington State health agencies lack consistency in how they regulate, license, or otherwise attempt to manage child cares served by septic systems. Conflicting and vague regulations from the Department of Early Learning (DEL), the Department of Health (DOH), and the local health jurisdictions (LHJs) have perpetuated a system where some child care providers are governed by stringent enforcement while others have literally no wastewater oversight. Much of this problem is based on the lack of septic system expertise within DEL and the lack of child care experience within DOH and LHJs. The Snohomish Health District Child Care Program surveyed LHJ water and wastewater programs throughout Washington State in 2006. The survey results indicate substantial inconsistencies at the local level. However, most local health jurisdictions would like to resolve regulatory inconsistencies and find common ground between the agencies involved.

## Background

DEL recognizes that it does not have the expertise or resources to effectively manage child care septic systems. In response, it has essentially given that authority over to DOH and the LHJs by way of the child care licensing regulations. For child care centers, WAC 170-295-5080 states that "If you have an on-site sewage system, you must have written verification that the system has been approved by the department of health or local health jurisdiction." Thus, DEL child care licensors must rely on DOH or the LHJ to ensure the child care has an acceptable wastewater disposal system. There is a consistent lack of communication between DEL and health agencies and as a result, many of these child care centers are unknown to the health agencies and therefore unregulated. LHJs also interpret "approved" septic systems in different ways: some will consider the system acceptable until it shows signs of malfunction while others require detailed flow measurements and a corresponding septic design to match the intended use.

DEL licensing requirements for family home child cares addresses onsite sewage systems under WAC 170-295-1150. This WAC states, "Your home must discharge sewage and liquid wastes into a public sewer system or into an independent septic system maintained so as not to create a public health nuisance as determined by the local health authority." There is no statewide requirement in the DEL licensing regulations for LHJ approval prior to opening a family home child care business. It is likely that this WAC was purposely written in a vague manner so that each LHJ could address the issue in a way that fits their mission, staffing, and budget.

By law the LHJ is the responsible agency for oversight of on-site septic systems and for enforcing the on-site sewage system WAC 246-272. This WAC does not specifically address family home child cares, but has requirements for expansions and changes of use. Ideally, this WAC should be applied to the entire public universally, including child care providers. However, if made to follow this regulation absolutely, most home child cares would not be able to operate. This fact, coupled with the lack of clear direction in the DEL

licensing WAC created inconsistency statewide in how LHJs manage child cares served by septic systems. Some counties are providing septic guidance for child cares just as they would for a residential property owner while others are treating child care operations as a business, more closely adhering to WAC 246-272. Some counties have not addressed child care septic systems in any fashion. Still other counties have developed specific evaluation and education processes for family home child care septic systems.

The lack of consistency from the state level down through the counties has not gone unnoticed by child care providers, their unions, and legislators. Many providers have become so frustrated by regulatory inconsistencies associated with waste water disposal that they have pursued this matter with the Washington State Legislature during the 2006 session by introducing a bill into session that would completely prevent interaction by health agencies. Such a restriction could lead to detriment to the health of the children, the value of the property, and the condition of the environment.

Child care providers generally are not well compensated and therefore have substantial concerns with cost and fee-based services when working with local environmental health departments. Most LHJs do not have adequate funding to provide these services at no cost. Additionally, child care service is in high demand across Washington State and DEL recognizes the need to keep child care providers in operation, including those in rural areas where public sewer is unavailable.

Child care providers, who have the perception of being over-regulated, frequently demonstrate great resistance regarding septic system oversight. This perception, in conjunction with the inconsistencies regarding septic system regulations and enforcement, has created political conflict with the involvement of the child care union and some local legislators.

**Points of Contention**

- Water usage in child care is typically high due to activities like handwashing, toileting, food preparation, and laundry. High water usage can increase the likelihood of septic system failure. Many child care centers and nearly all family child care homes are served by a septic system that was not designed or installed for the purposes of child care. The increased flows from the child care can surpass the design of the septic system, leading to a system failure and exposing children to disease-causing organisms in sewage.
- DEL licenses child cares but does not have the technical expertise or human resources to effectively manage child care septic systems. Conversely, DOH and LHJ's have technical expertise to manage septic systems but do not have the knowledge and experience of working with child care providers.
- Child care WACs 170-296-1150 and 170-295-5080 are ambiguous regarding septic systems. These regulations imply active LHJ or DOH inspection and monitoring of child care septic systems. Unfortunately, LHJs do not manage these systems consistently, if at all. Due to the shortage of LHJ involvement with child care septic systems and the lack of licensor knowledge about septic systems, licensors often discount the regulation altogether. The regulations should be revised to explicitly state what is required to demonstrate adequate wastewater disposal. LHJs must also have clear expectations about their role in the process and be provided with dedicated funding to ensure consistent oversight in all jurisdictions.
- Providers lack knowledge on how septic systems work and the risks involved in operating a child care on a septic system. Common problems encountered by LHJ staff who visit child cares include: using more water then the design capacity, lack of regular septic tank pumping, installing large playground structures over the drainfield, unfulfilled maintenance agreements for advanced technology septic systems, and lack of a reserve area. The majority of child care providers do not realize they are jeopardizing the integrity of the septic system.
- Child care providers often times lack the financial resources needed to correct or upgrade systems when out of compliance. Septic systems are costly to replace or expand. Many child care providers would be forced to close if septic systems were required to be redesigned for business use.

**Conclusions**

The need for DOH, DEL, and LHJs to find practical and reasonable solutions to the child care septic system issue is paramount. To effectively solve child care wastewater concerns in Washington State, a comprehensive action plan that is consistently understood and enforced statewide is critical. The political sensitivity of the issue should not deter corrective regulatory action and enforcement. The regulatory interpretation, management, and enforcement must be reasonable, practical, and universally understood between all agencies involved with the need of protecting the health and safety of children in child care while recognizing the aim to keep child care business owners in operation.

07/01/07
ND/MH/LAC

**3.**

# Regulatory Oversight of Well Water for Washington State Child Care Programs Briefing Paper

**Authored by the Washington State Child Health and Safety Advisory Committee**

**July 1, 2007**

## Scope

Safe drinking water is a basic public health expectation. Parents expect that the water their children drink while enrolled in child care is free of bacterial and chemical contamination. Across Washington State, the approach to ensuring safe drinking water in child cares has been inconsistent and ineffective. Conflicting and vague regulations from the Department of Early Learning (DEL), the Department of Health (DOH), and the local health jurisdictions (LHJs) have perpetuated a system where some child care providers are burdened with overly stringent enforcement while others have no drinking water oversight at all. Much of this problem is based on the shortage of well water expertise within DEL and the corresponding shortage of child care experience within DOH and LHJs. The Snohomish Health District Child Care Program surveyed LHJ water and wastewater programs throughout Washington State in 2006. The survey results indicate substantial inconsistencies at the local level. However, most local health jurisdictions would like to resolve regulatory inconsistencies and find common ground between the agencies involved.

## Background

Current drinking water regulations for family home child care providers are ambiguous. WAC 170-296-1140 states that family home child care providers served by wells must have "An individual water supply operated and maintained in a manner acceptable to the local health authority or commercially bottled water". DEL child care licensors often rely on the LHJ for public health expertise to ensure the child care has a satisfactory well water supply. However, many LHJs do not actively work with family home child care providers and these wells are often ignored. LHJs also have varying interpretations of "acceptable" drinking water; some provide annual water testing while others enforce full Group B standards.

DEL drinking water regulations for child care centers are more definitive, but have enough ambiguity to allow multiple interpretations. WAC 170-295-5070 states that child care centers must "receive drinking water from a public water system approved by and maintained in compliance with either DOH or a LHJ under chapter 246-290 WAC (Group A systems) or chapter 246-291 WAC (Group B systems) or have a source of potable water approved for child care center use by DOH or the LHJ."

Child care providers generally are not well compensated and therefore have substantial concerns with cost and fee-based services when working with local environmental health departments. Most LHJs do not have adequate funding to provide these services at no cost. Additionally, child care service is in high demand across Washington State and DEL recognizes the need to keep child care providers in operation, including those in rural areas where public water is unavailable.

Regarding well water oversight, there is often great resistance from child care providers, who have the perception of being over-regulated. This perception, in conjunction with the inconsistencies regarding well water regulations and enforcement, has created political conflict with the involvement of the child care union and some local legislators.

## Points of Contention

- Child care WACs 170-296-1140 and 170-295-5070 are ambiguous regarding drinking water from wells. These regulations imply active LHJ inspection and monitoring of child care wells. Unfortunately, LHJs do not manage these WACs consistently, if at all. Due to the shortage of

LHJ involvement with child care wells, licensors often ignore the regulation altogether or must rely on child care provider-supplied lab reports which do not tell the whole story. These regulations should be revised to explicitly state what is required to demonstrate safe drinking water availability, such as a sanitary survey followed by annual well water testing.

- Many child cares homes have unsatisfactory drinking water. For example, in Snohomish County, approximately 33% of home child care wells tested produce unsatisfactory samples each year. This would not be known, except that the Snohomish Health District provides annual testing at no charge as a service to child care providers. Evaluation of these wells by Snohomish Health District shows the majority of these unsatisfactory samples result from poorly sealed wells, which must be repaired for a well to provide safe water. It is likely that unsatisfactory wells are currently serving hundreds of children in Washington State licensed child care.
- Some licensors rely on providers to show a lab slip stating the bacteriological quality of the water is satisfactory upon relicensing, which occurs every 3 years. This frequency is inadequate. Additionally, child care licensors are rarely notified when a provider's well produces an unsatisfactory sample. The well is often disinfected without repair, and a satisfactory sample is produced to show the licensor. The well remains in disrepair and the contamination promptly returns unnoticed and unchecked. Additionally, other contaminants with serious health risks, such as arsenic and nitrate, are not monitored at all.
- Some counties have a Joint Plan of Operation (JPO) agreement with DOH, and therefore are responsible for enforcing Group B standards. A family home child care is a business and according to DOH is therefore responsible to provide safe water to their customers, the children. However, Group B standards are too stringent for most home child care residences to meet (specifically set-backs and source protection). Thus, requiring all Group B standards will force many rural home child cares to close or operate without a license. Involved agencies should reconsider how child cares are managed under Group B regulations.
- Some family home child care providers cannot supply satisfactory well samples and opt to use bottled water in accordance with DEL WAC 170-296-1140. However, a business that uses bottled water is not in full compliance with DOH's Group B standards. Therefore, some LHJs allow child care providers to use bottled water and others do not, further complicating inconsistencies between DOH, DEL, and LHJs. It is also important to note that child care centers can not use bottled water as a replacement for unsatisfactory well water, while family home child cares can.

## Conclusions

The need for DOH, DEL, and LHJs to find practical and reasonable solutions to the child care well water issues is paramount. To effectively solve child care water quality concerns in Washington State, a comprehensive action plan that is consistently understood and enforced statewide is critical. The political sensitivity of the issue should not deter corrective regulatory action and enforcement. The regulatory interpretation, management, and enforcement must be reasonable, practical, and universally understood between all agencies involved with the aim of protecting the health and safety of children in child care while recognizing the need to keep child care business owners in operation.

**4.**

**NOTES ON: Infant Feeding and Care, Elaine Ruhlman, Child Care Health Specialist, Benton-Franklin Health District**

*NRMT note: Text in RED are Ms Ruhlman's suggestions for the rule content. After each subsection is her recommended "best practice" advice in bold…af*

3. INFANT CARE

g. Are there any state laws or rules regarding infant feeding? If no, what are considered "best practices" for infant feeding?

Yes…WACs 170-296-0960

Washington State Register filings since 2003

## *WAC 170-296-0960*

What requirements must I meet for feeding infants?

You must meet the following requirements for feeding infants:

(1) All formulas and breast milk must be in clean and sanitized bottles with nipples and labeled with the child's name and date prepared.

(2) If the bottle has been sitting at room temperature for an hour or more, you must throw away the contents.

(3) You must keep bottle nipples covered when not in use.

(4) If you reuse bottles and nipples, you must wash and sanitize them by washing, rinsing and then boiling for one minute.

(5) You must hold infants, who are 8 months old and younger, while feeding and recognize infant cues for hunger, satiation, interaction and rest. (Keys to Caregiving, NCAST, 1999)

***Best Practice:*****During feeding display sensitivity by holding the infant in order to see the infants face and eyes, feel baby's body movements and position the baby to insure safe food intake. Enables provider to appropriately read and respond to infant cues: Recognize cues for hunger, satiation, interaction and rest.** *(Keys to Caregiving, NCAST, 1999)*

(6) Infants who are nine months of age or over, who want to hold their own bottles may be held on your lap and given a cup or bottle or placed in a highchair and given a cup or bottle if you or a primary staff person remain in the room, within eyesight.
***Best Practice*****: Introduce a cup when baby begins to prefer to hold his/her own bottle. Provide cups when baby can hold his/her neck straight, shows no outward tongue thrust and indicates interest and can swallow without gagging or choking. Cups should be given only when infant is in a seated position (sitting in a highchair or on a provider's lap with back support. (***American Academy of Pediatics, American Dietetic Association, Caring for our Children.***)**

(7) You must take bottles from the child when the child finishes feeding, or when the bottle is empty.
***Add instead:*** Feed babies the amount of formula or breast milk or whole milk they want depending on their feeding cues.
***Best Practice*****: Recognize and appropriately respond to infant feeding and satiation (feeding satisfaction) cues. Do not intentionally feed baby until he/she falls asleep, drinks a specified amount of liquid or for a specified period of time. Avoid disrupting a feeding for burping or other reasons if the infant indicates dissatisfaction with the change.** *Keys to Caregiving, NCAST, 1999*

(8) You must directly feed an infant from a bottle or cup, not prop a bottle when feeding an infant. Move to below " You must hold an infant when feeding".
***Best Practice:To help promote attachment with care giver, babies need to be held and directly fed during feeding to promote positive feeding interaction and contribute to a child's development. Propping***

***is directly associated with pooling of bottle contents and increased risk of baby bottle tooth decay.*** *(Keys to Caregiving. NCAST, 1999)*

(9) You must not give a bottle or tippy cup to a child who is lying down.
***Best Practice:*****Babies should be held while drinking a bottle or sitting in a supported position in a chair or adult lap when drinking from a cup. Recognize and appropriately respond to infant cues indicating tiredness, need for a rest or break from interaction. Help soothe baby and provide comfort measures other than bottle and tippy cup: soft, reassuring phrases, massage back, sing, rock and read, provide piece of mother's clothing during cuddling and in the crib.**

(10) You must not use a microwave oven to warm formula or breast milk or whole milk in a bottle used for feeding.
Add: Microwaving can cause hot spots in either liquid; microwaving for too long or heating above 130º may change the properties (quality) of the breast milk. (La Leche League's The Breastfeeding Answer Book, 1997)

**Consider Adding 11 - 16:**
11. Introduce solid foods to babies according to parent's guidelines.
**Best Practices: Work closely with parents and provide information about infant feeding guidelines when indicated. Follow CACFP Child Care Infant Meal Pattern, 2002 for portion sizes and infant feeding guidelines to share with parents. To help minimize food intolerance and allergies it is recommended to introduce foods one at a time beginning with iron fortified infant cereal around 6 months of age but not before child is developmentally ready. (**Bright Futures, Nutrition, 2006)

12. You must be in the same area and within sight of a baby feeding in a highchair or chair.

13. Face babies during feeding and feed them using a spoon.

**Best Practices: A supervising adult promotes a child's safety by discouraging activities that may lead to choking. You must be seated at the same table or within an arm's reach of a feeding baby. (Caring for Our Children, 2002)**

14. Place finger foods directly on a sanitized stainless steel, plastic tray or non-breakable dish. *(May be covered under food safety section)*

15. Do not offer foods implicated in choking hazards (round, hard, small, sticky, smooth or slippery foods).

16. Follow CACFP Child Care Infant Meal Pattern, 2002 for portion sizes and guidelines.

**Best Practices: Finger foods allow a baby to explore foods with greater texture than spoon fed foods and further develop food acceptance and eating capabilities. Provide finger foods that have been given by parents or primary care-givers first. Stay close when babies are eating any solid foods to help prevent a choking incident. Modify foods from home or from the menu to eliminate foods implicated in choking incidents. Omit hotdogs, nuts, seeds, raw vegetables, grapes, berries, pretzels, chips, peanuts, popcorn, chunks of cheese or meat, peanut butter.** (Caring for Our Children, 2002; Bright Futures, Nutrition, 2006)

h. What are the recommended practices for storing and serving breast milk?
Storage: Label the contents with the child's name, date pumped and date it was brought into the center. It can be kept for one hour out of fridge; 1 day in fridge; 2 weeks in the freezer compartment of a refrigerator at 10º F or less. Thawed breast milk can be refrigerated but not re-frozen. Keep breast milk in the coldest part of the refrigerator, i.e. toward the back of the shelf and away from the door.
Serving: Thaw the breast milk in the refrigerator, under warm running water or in a pan of warm water. Never microwave breast milk because valuable components can be killed above 130ºF. If heated in a crock pot, maintain temperature of water at 120º or less. Shaking breast milk too hard in a bottle may damage it. Gently swirling the milk in the bottle to even out the temperature is the safest practice.

c. How should water be heated for making baby formula? Would using a "tankless" instant hot water system make any difference in how formula should be prepared? Water, when mixed with formula, should be at 35-75ºF and if boiled first should be cooled to 100ºF or less before mixing with formula. Generally, a "tankless" instant hot water system is too hot. It would have to be set for no hotter than 100ºF or water would have to be cooled to that temperature or below in order to be used. Water above 100ºF can destroy some of the important components of the formula and may also cause it to clump and not mix well. (Information on formula prep from Mead-Johnson, makers of Enfamil formula, see attached letter,)

d. Besides not heating foods in plastic containers, are there any other concerns about storing or serving foods in plastic containers? Currently we're not sure how strong the requirements should be but a reasonable view was voiced by Mel Suffet, a public health professor and environmental chemist at UCLA. He said he doesn't know for sure how harmful BPA is or isn't. But he has no trouble figuring out what to do about it. "Why use something with a potential danger?" he asks. "It's kind of silly. Better safe than sorry. If it's hard and clear and doesn't say 'No BPA,' don't use it."

Avoid putting polycarbonate plastic food containers in the microwave or dishwasher. (By that token, you might also want to avoid putting hot food or hot liquid into polycarbonate plastic containers.) Heat makes BPA leach out much faster than it does otherwise.

Note: Most (but not all) plastics with a No. 7 recycling code are polycarbonates and therefore contain BPA.

* Eat/Serve fewer canned foods.

* Use glass, porcelain or stainless steel containers when possible, especially for hot food or drinks.

* Don't use polycarbonate baby bottles. (from an article By Karen Ravn, Special to The Times May 19, 2008)

e. What is the current recommended infant sleeping practice to help prevent SIDS?

Place baby in crib on its back to sleep. (Once a baby can roll over on its own, allow it too. Not necessary to keep rolling it over onto its back. Always start a baby out on its back when putting it down to sleep.)

Baby's feet should be a few inches from the foot of the crib. "Feet to Foot."

When baby is awake and alert put it on its tummy to play several times per day in a designated infant area.

* If baby falls asleep on its tummy, immediately roll baby over and as soon as possible place baby in crib to sleep. When babies, who are accustomed to sleeping on their backs, fall asleep on their tummies there is an 18-times increase in the chance of a SIDS death occurring.

* It is important to educate parents about the risk of tummy sleeping. Some parents are becoming complacent and are letting their babies sleep on tummies at home.

*About 1 baby in 1000 dies of SIDS. We do not know which baby that will be. (In WA State, there were 50 who died in 2006; in 1994 there were about 200 who died of SIDS.)

Place baby on a firm sleep surface (mattress) covered by a fitted sheet.

If using a light weight blanket, lay it across the baby at the armpit level and tuck it around the sides and end of the mattress. A one piece sleeper and no blanket would be preferred.

Keep soft objects, toys, loose bedding, pillows, bumper pads out of crib. Do not hang extra blankets, burp rags, bibs, etc. on sides or ends of crib. Keep all items away from baby's face while sleeping.

If baby takes a pacifier give it to him/her when putting down to sleep, but don't force baby to take one if they are not used to using it. Not necessary to keep putting it back into baby's mouth as they sleep.

Do not let baby get overheated during sleep. Keep room at about 68-72$^{o}$F.

No smoking around babies.

*Child care providers who smoke must do so outside, with an overcoat or smock on over their clothes. The overcoat or smock will be removed when they return to work.

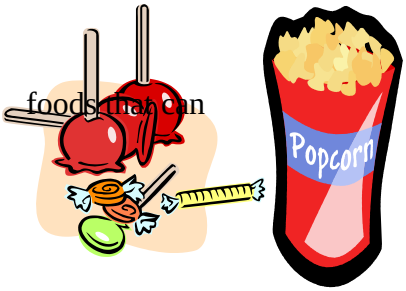
Avoid too much time in containers: car seats, carriers, bouncers, exer-saucers (any equipment): more than 10-15 minutes 4 times per day is too much.

*A young baby slouches over due to lack of upper body strength and cannot fully expand its chest when breathing… 4 times increase in risk for SIDS deaths when babies are in containers for long periods. Being in the positions that containers force also contributes to "flat heads." Do not move from one container to another. Instead, go from container to providers' arms to floor to container to floor to crib (for sleeping only) to arms, etc.

f. Do you have other best practice guidance about infant feeding, sleeping or other infant care?

Babies (and all children) need to get outside every day for fresh air and sunshine. Take them out before 10 a.m. for about 20 minutes. Can use a plastic-covered mat or quilt to lay non-mobile infants on. In winter if children are not taken outside while at child care they don't get to be in the sunshine and fresh air because it's usually dark when they arrive and dark when they go home. Rickets is on the increase as is osteoporosis in older ages… these may be traced back to lack of the sunshine vitamin (Vitamin D) in the early years. Even in the winter time there are fewer germs outside in the cold air than in the enclosed building so it's also healthier in that respect.

# PREVENT CHOKING IN CHILDREN




The following list provides examples of foods that can

cause choking in young children. Although children can choke on any food, foods that are hard or tough to chew, slippery, small and round or sticky present an increased risk.

## INFANTS & TODDLERS
**(Ages ~9 months thru 2 years)**

### AVOID

Raw carrots
Crisp apples
Hot dogs
Link sausage
Hard candy
Grapes
Popcorn
Tortilla chips
Nuts (unless ground)
Hard cookies/teeth biscuits
Whole kernel corn
Raw peas
Chewing gum
Processed cheese-chunks/slices
Cherries
Marshmallows

### USE EXTRA CAUTION WITH:

Raw veggies – steam to make easy to chew, unless naturally soft.
Apples – choose mushy, peel & slice thin
Cookies – soft, easy to chew
Beans – cook well, mash or cut up
Macaroni – cook soft
Breads – use easy to chew breads – use extra caution with bagels
Peanut butter – always mix with liquid (juice, mashed fruit, jelly) to decrease stickiness, or spread very thin on a cracker, crumbly bread or toast
Meats – cook until soft and easy to chew, cut up or grind into small pieces

**Do Not** give any raw veggies until back teeth (2 year molars) are in

## PRESCHOOLERS
**(Age 3-6-years)**

### AVOID

Cherries with pits
Nuts (unless ground)
Hot dogs
Grapes
Hard candy
Chewing gum

### USE EXTRA CAUTION WITH:

Raw carrots – cut into very thin sticks
Meats – cook soft and easy to chew
Beans – cook well until easy to chew
Apples – slice into thin easy to chew slices
Peanut butter – thin to decrease stickiness or spread thin on crackers or bread

## OTHER TIPS FOR SAFELY FEEDING CHILDREN UNDER 6

1. Always supervise eating
2. Insist that children sit down to eat
3. Decrease environmental distractions during meal and snack times. (i.e. television, games, pets)
4. Avoid offering food in cars/busses.
5. Always have someone familiar with proper emergency measures present when children are eating.

(6/08 Benton-Franklin Health District Child Care Health Program--- Adapted from handout created by Seattle/King County Health Department)

**6.**

**NOTES FROM: Kathryn Quinn, DEL Health Specialist – Eastern Service Area**

Public Health Questions for
June 21, 2008 DEL Negotiated Rule Making

The Department of Early Learning (DEL) is engaged in 'negotiated rule making" to revise the licensing rules for Family Home Child Care in chapter 170-296 WAC. The Department has formed a Negotiated Rule Making Team (NRMT) comprised of child care providers, parent and provider advocates, the child care resource and referral network, Service Employees International Union, and DEL staff to gather information and recommend content for the revised rules.

From time to time, the NRMT plans to ask various subject matter experts to help the group understand current federal, state or local requirements related to providing child care, best-practices, or other information that would help promote a safe and healthy child care environment in DEL-licensed family homes.

1. SEPTIC SYTEMS [Please refer to the Washington State Child Health and Safety Advisory Committee briefing paper on on-site septic systems that Mark sent you as an attachment to his e-mail. This briefing paper is an excellent overview of the problems arising from lack of coordination among DEL, DOH, and the LHJs with regard to on-site septic systems in family child care homes.]

g. What are the statewide laws and rules regarding single-family residential septic systems?

h. Are the septic system laws and rules applied the same way statewide, or are there differences from one local health jurisdiction to another (please explain if the latter)?

i. How is single-family septic system capacity determined? How does running a family home child care affect this capacity?

j. How often should a septic system be checked? Does this vary depending on the type of system? Can the homeowner check the system, or does this need to be done by public health? What are typical costs of checking the system?

k. What are the health risks if a septic system isn't working properly? Infectious disease resulting from untreated sewage on the ground. Are there ways to tell – other than sight or smell – if the system isn't working or may be failing? The grass will appear greener in the drainfield area – you can often see green lines where the drainfield pipes are located.

l. Are there things the owner can do in their child care operation to help prevent septic problems?

2. WATER [Please refer to the Advisory Committee briefing paper on well water that Mark sent you as an attachment to his e-mail. This paper identifies the lack of consistency state-wide with regard to ensuring safe drinking water in family child care homes and recommends better coordination among DEL, DOH, and the LHJs.]

h. What are the statewide laws and rules regarding well water? Are they different if you are on a private well compared to a small community system (such as a water association)?

i. Are the well water laws and rules applied the same way statewide, or are there differences from one health jurisdiction to another (please explain if the latter)?

j. What are the main health concerns about well water? Are there concerns other than for drinking?

k. How often must a private well be inspected and/or tested? If not required, how often should the family home child care provider have the well inspected or tested?

l. What is considered an "acceptable" well water test? Who does the testing, and what does the test look for? How much does a water test costs typically?

m. If a family child care home uses bottled water for drinking/cooking, are there still concerns about using private well water for other uses?

n. Do water filters affect the fluoride content in water from a water system that adds fluoride? If yes, what can the child care provider do to replace the fluoride in the water?

3. SANITIZING

c. **Bleach**. Are there any health risks of residues or fumes from using bleach sanitizing solutions around children? If there may be risks, what are ways to reduce the risks? If appropriate dilutions are made, it is unlikely that there would be any adverse health effects. Bleach solutions should not be sprayed on surfaces when children are in direct contact with those surfaces (e.g. – don't spray bleach water on the dining table when children are seated there).

d. **Bleach Alternatives**.

iii. Are there products that are acceptable alternatives to bleach? Quaternary ammonia compounds (such as dimethylbenzylammoniumchloride) are approved sanitizers if the concentration and contact time are appropriate. Also the label must specify that the product is safe to use in food preparation areas...Are the alternative products safe to use around children and in food preparation/serving areas?

iv. Lysol brand markets professional products as part of 'child care hygiene program." Are there any health or safety concerns about using these products around young children? Need manufacturers label information regarding active ingredients, concentration, contact time, and whether it is safe to use in food preparation areas.

d. **Sanitizing surfaces**.

i. When changing diapers, is there a benefit to washing the child's hands if the child didn't touch the diaper area? Yes. The child's hands may have come into contact with other contaminated surfaces. It is an excellent way to begin teaching that handwashing always follows toileting activities.

ii. If disposal changing pads are used, is it necessary to sanitize the changing area? Yes. Contamination is not always visible.

iii. What is the best way to sanitize toys and other items that children have had (or will likely have) in their mouths? Toys can be sanitized in the dishwasher or manually using a bleach solution. Do sanitizing solutions affect the materials in toys, and is this a concern? If appropriate bleach dilutions are used, adverse effects on the materials in toys should be minimal. It is important to prevent disease transmission by sanitizing toys between uses by different children.

3. INFANT CARE [Please refer to "Caring For Our Children, 2nd Ed." Standards 4.011, 4.012, 4.013, 4.014, 4.015, 4.016, 4.017, 4.018, 4.019, 4.020, and 4.021. Hazel attached these standards to the e-mail reply she sent you.]

i. Are there any state laws or rules regarding infant feeding? If no, what are considered "best practices" for infant feeding?

j. What are the best practices for storing and serving breast milk?

k. How should water be heated for making baby formula? Would using a "tankless" instant hot water system make any difference in how formula should be prepared?

**7.**

**NOTES FROM: Hazel Philp, DEL Health Specialist – Northwest Service Area**

Public Health Questions for
June 21, 2008 DEL Negotiated Rule Making

The Department of Early Learning (DEL) is engaged in 'negotiated rule making" to revise the licensing rules for Family Home Child Care in chapter 170-296 WAC. The Department has formed a Negotiated Rule Making Team (NRMT) comprised of child care providers, parent and provider advocates, the child care resource and referral network, Service Employees International Union, and DEL staff to gather information and recommend content for the revised rules.

From time to time, the NRMT plans to ask various subject matter experts to help the group understand current federal, state or local requirements related to providing child care, best-practices, or other information that would help promote a safe and healthy child care environment in DEL-licensed family homes.

1. SEPTIC SYTEMS *((See position paper put forth by Advisory Committee) Snohomish Health District's Child Care Health Program will have a great deal of input on this subject. I've added my experiences briefly.)*

m. What are the statewide laws and rules regarding single-family residential septic systems?

*n.* Are the septic system laws and rules applied the same way statewide, or are there differences from one local health jurisdiction to another (please explain if the latter)? *There are differences that appear to depend upon funding and jurisdictional practices. Some counties (e.g., Snohomish) are very involved in septic issue in child care, others not so much).*

o. How is single-family septic system capacity determined? *(per bedroom)* How does running a family home child care affect this capacity? *(Because of increased capacity systems sometimes have to be upgraded, which can be very expensive.*)

p. How often should a septic system be checked? *(Depends on the system. I've heard from annually to every 2-3 years) Does this vary depending on the type of system? Can the homeowner check the system, or does this need to be done by public health? (Conflict of interested with home owner oversight)* What are typical costs of checking the system?

*q.* What are the health risks if a septic system isn't working properly? (*Infectious disease from direct contact and from indirect (run off)* Are there ways to tell – other than sight or smell – if the system isn't working or may be failing? *(Buttercups)*

r. Are there things the owner can do in their child care operation to help prevent septic problems? *(Educate staff, parents, and children: 1. use single-ply toilet paper and as*

*little as is necessary; 2. Don't flush anything down the toilet aside from waste and toilet paper (e.g., left over medications-antibiotics will kill the good bacteria needed to breakdown the waste).*

2. WATER *(See position paper put forth by Advisory Committee)*

o. What are the statewide laws and rules regarding well water? Are they different if you are on a private well compared to a small community system (such as a water association)?

p. Are the well water laws and rules applied the same way statewide, or are there differences from one health jurisdiction to another (please explain if the latter)?

q. What are the main health concerns about well water? Are there concerns other than for drinking?

r. How often must a private well be inspected and/or tested? If not required, how often should the family home child care provider have the well inspected or tested?

s. What is considered an "acceptable" well water test? Who does the testing, and what does the test look for? How much does a water test costs typically?

t. If a family child care home uses bottled water for drinking/cooking, are there still concerns about using private well water for other uses?

u. Do water filters affect the fluoride content in water from a water system that adds fluoride? If yes, what can the child care provider do to replace the fluoride in the water?

3. SANITIZING

**Bleach**. Are there any health risks of residues or fumes from using bleach sanitizing solutions around children? *(Check MSDS for specific exposure risks: DANGER: CORROSIVE. May cause severe irritation or damage to eyes and skin. Vapor or mist may irritate. Harmful if swallowed. Keep out of reach of children. Some clinical reports suggest a low potential for sensitization upon exaggerated exposure to sodium hypochlorite if skin damage (e.g., irritation) occurs during exposure. Under normal consumer use conditions the likelihood of any adverse health effects are low. Medical conditions that may be aggravated by exposure to high concentrations of vapor or mist: heart conditions or chronic respiratory problems such as asthma, emphysema, chronic bronchitis or obstructive lung disease.) If there may be risks, what are ways to reduce the risks? (Use correct dilutions, apply the bleach solution when children are not present (e.g., clean and sanitize tables after food service when children have gone outside to play, wait until child has been returned to classroom area before spraying bleach solution on diaper changing table (avoid overspraying when using sanitizing solution), etc.*

e. **Bleach Alternatives**.

v. Are there products that are acceptable alternatives to bleach? Are the alternative products safe to use around children and in food preparation/serving areas?

*vi.* Lysol brand markets professional products as part of 'child care hygiene program." Are there any health or safety concerns about using these products around young children? *(Again, checking the MSDS on the following product: LYSOL® All Purpose Cleaner with Bleach, it states to only use in well ventilated areas and to avoid prolonged exposure to fumes. This product combines a cleaner and sanitizer, which doesn't follow center WAC requirements for a 3-step process. In addition, the product information states that for matter on surfaces the product has to be left on for at least 5 minutes, which doesn't make sense in a child care setting on a consistent basis.)*

e. **Sanitizing surfaces**.

*i.* When changing diapers, is there a benefit to washing the child's hands if the child didn't touch the diaper area? *(It's not just about the child touching the diapering area; it's also about the provider touching the hands of the infant/toddler when s/he is changing the diaper or the child touches something else that may not have been cleaned/sanitized yet. It's obviously not always the case that the child's hands will need to be washed, but given the vulnerability of this population I believe it's a wise preventive measure.)*

ii. If disposal changing pads are used, is it necessary to sanitize the changing area? *(Again, this is a preventive measure. If there isn't any gross fecal/urine that's observed on the diaper changing table, it doesn't mean it's not there, especially if the child's hands aren't going to be washed after each changing. Clearly it would be easier and more efficient to clean and sanitize after each changing only when fecal/urine is observed, but I think this is a slippery slope.)*

iii. What is the best way to sanitize toys and other items that children have had (or will likely have) in their mouths? *(Either in dishwashers that are capable of sanitizing via temperature or solution, or in tubs of water with sanitizing solution) Do sanitizing solutions affect the materials in toys, and is this a concern? (Yes, sanitizing solutions can break down toys/affect materials in toys, but it is more important to sanitize the toys than it is to preserve their aesthetic qualities. If the physical integrity of the toys are in question, they should be replaced.)*

3. INFANT CARE *(See attached documents and links)*

l. Are there any state laws or rules regarding infant feeding? If no, what are considered "best practices" for infant feeding?

*m.* What are the best practices for storing and serving breast milk? *(see attached section from Sea-King CCHP's Health Policy template)*

n. How should water be heated for making baby formula? Would using a "tankless" instant hot water system make any difference in how formula should be prepared?

o. Besides not heating foods in plastic containers, are there any other concerns about storing or serving foods in plastic containers?

p. What is the current recommended infant sleeping practice to help prevent SIDS?

q. Do have other best practice guidance about infant feeding, sleeping or other infant care?

4. TB TESTS FOR CHILD CARE STAFF

What is the most current TB testing regimen, and how does it compare with the requirement in DEL WAC 170-296-0160(2)(b), which is: "*(b) Documentation of a negative Mantoux tuberculin (TB) test in the twelve months prior to starting work for you, staff, volunteers and members of the household sixteen years or older*;"…

I've inserted my responses into your original document and attached additional information for your review. I've also include a link that will take you to the American Academy of Pediatric's Healthy Childcare website where there's a great deal of information: http://www.healthychildcare.org/

I've also included a link to the HTML format of "Caring For Our Children, 2nd Ed," where you can find a great deal of information on best practices for Child Care, as Mark pointed out:
http://nrc.uchsc.edu/CFOC/HTMLVersion/TOC.html

Thanks for the opportunity to participate in this important process. Please let me know if there's anything else I can do to help.

**8.**

*From* Caring For Our Children, 2nd Ed.

## *TUBERCULOSIS*

***STANDARD 6.014***
***MEASURES FOR DETECTION AND CONTROL OF TUBERCULOSIS***

*Local and/or state public health authorities shall be notified immediately about suspected cases of tuberculosis disease involving children or child care providers in the child care setting. Facilities shall cooperate with their local health department officials in notifying parents of children who attend the facility about exposures to children or staff with tuberculosis disease. This may include providing the health department officials with the names and telephone numbers of parents of children in the classrooms or facilities involved.*

*Tuberculosis transmission shall be controlled by requiring regular and substitute staff members and volunteers to have their tuberculosis status assessed with a one-step or two-step Mantoux intradermal skin test prior to beginning employment unless they produce documentation of the following:*
*a) A positive Mantoux intradermal skin test result in the past, or*
*b) Tuberculosis disease that has been treated appropriately in the past.*

*The one-step Mantoux intradermal tuberculin test shall suffice except that for individuals over 60 years of age or those who have a medical condition that reduces their immune response, the use of the two-step method is required. Individuals with a positive Mantoux intradermal skin test or tuberculosis disease in the past shall be evaluated with chest radiographs and shall be cleared for work by their physician or a health department official. Review of the health status of any staff member with a positive Mantoux intradermal skin test or tuberculosis disease in the past shall be part of the routine annual staff health appraisal (21).*

*In large and small family child care homes, this requirement applies to all adolescents and adults who are present while the children are in care.*

*Tuberculosis screening by Mantoux intradermal skin testing, using the one-step procedure, of staff members with previously negative skin tests shall not be repeated on a regular basis unless required by the local or state health department. Anyone who develops an illness consistent with tuberculosis shall be evaluated promptly by a physician. Staff members with previously positive skin tests shall be under the care of a physician who, annually, will document the risk of contagion related to the person's tuberculosis status by performing a symptom review including asking about chronic cough, unintentional weight, unexplained fever and other potential risk factors.*

*RATIONALE: Young children acquire tuberculosis infection from infected adults or occasionally, infected adolescents (21). Tuberculosis organisms are spread by inhalation of a small particle aerosol produced by coughing or sneezing by an adult or adolescent with contagious (active) pulmonary tuberculosis. Transmission usually occurs in an indoor environment. Tuberculosis is not spread through objects such as clothes, dishes, floors, and furniture.*

*The one-step Mantoux method of intradermal PPD skin testing involves injecting the material known as PPD into the skin so that a bleb is raised as the material is injected. For most healthy individuals, the one-step test is sufficient to detect latent TB or active TB disease. TB testing depends on cell-mediated immunity and the anemnestic or memory response where the body recalls a previous encounter with the antigen and reacts to it. In older individuals and those who have one of a group of specific conditions that reduce immune response, the first Mantoux test can produce a false negative response to a first test. In these individuals, the two-step method is recommended, involving repeating the Mantoux test procedure with an interval of at least one week to get an accurate result. Anamestic memory for most antigens occurs within one week after stimulation with the substance - thus a second test may be positive when a first is negative and indicate that an individual has latent TB or TB*

*disease. The need for a two-step test for individuals under 60 years of age should be determined by the clinician performing the test or by the local department of health.*

*COMMENTS: The two stages of tuberculosis are:*
*a) Latent tuberculosis infection, when the tuberculosis germ is in the body and causes a positive Mantoux intradermal skin test but does not cause sickness;*
*b) Active tuberculosis (tuberculosis disease), when the tuberculosis germ is in the body and causes sickness. Virtually all tuberculosis is transmitted from adults and adolescents with tuberculosis disease. Infants and young children with tuberculosis are not likely to transmit the infection to other children or adults because they generally do not produce sputum and are unable to forcefully cough out large numbers of organisms into the air.*

*Only Mantoux intradermal skin test, containing 5 tuberculin units of purified protein derivative administered intradermally, should be used for skin testing. Multiple puncture tests should no longer be used because several problems severely limit their use. Problems include a lack of antigen standardization, false-positive and false negative results, and variable sensitivity and specificity.*

*For additional information regarding tuberculosis, consult the Red Book from the American Academy of Pediatrics (AAP). Contact information for the AAP is located in Appendix BB.*

*TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home*

## *STANDARD 6.015*
## *ATTENDANCE OF CHILDREN WITH TUBERCULOSIS INFECTION*

*Children with tuberculosis infection or disease can attend child care if they are receiving appropriate therapy.*

*RATIONALE: Children can return to regular activities as soon as effective therapy has been instituted, adherence to therapy has been documented, and clinical symptoms have disappeared. If approved by local health officials, children may attend out-of-home child care once they are considered non-infectious to others.*

*COMMENTS: For additional information regarding tuberculosis, consult the Red Book from the American Academy of Pediatrics (AAP). Contact information for the AAP is located in Appendix BB.*

*TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home*

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## 4.3 REQUIREMENTS FOR SPECIAL GROUPS OR AGES OF CHILDREN

NUTRITION FOR INFANTS

### STANDARD 4.011
### GENERAL PLAN FOR FEEDING INFANTS

At a minimum, meals and snacks the facility provides for infants shall contain the food in the meal and snack patterns shown in Appendix P. Food shall be appropriate for infants' individual nutrition requirements and developmental stages as determined by written instructions obtained from the child's parent or health care provider.

The facility shall encourage and support breastfeeding. Facilities shall have a designated place set aside for breastfeeding mothers who want to come during work to breastfeed (18-24).

The facility shall offer solid foods and fruit juices to infants 6 months of age and younger only upon the recommendation of the parent and the child's health professional.

RATIONALE: Human milk or iron-fortified formula is the infant's first food and supports rapid growth in both weight and length during the first year of life and beyond. Human milk, as an exclusive food, is best suited to meet the entire nutritional needs of an infant from birth until 6 months of age. Human milk is the best source of milk for infants for at least the first 12 months of age and, thereafter, for as long as mutually desired. Breastfeeding protects infants from many acute and chronic diseases and has advantages for the mother, as well.

Advantages for the infant include reduction of some of the risks that are greater for infants in group care. The advantages of breastfeeding documented by research include reduction in the incidence of diarrhea, lower respiratory disease, otitis media, bacteremia, bacterial meningitis, botulism, urinary tract infections, necrotizing enterocolitis, SIDS, insulin-dependent diabetes, lymphoma, allergic disease, ulcerative colitis, and other chronic digestive diseases (20, 21). Some evidence suggests that breastfeeding is associated with enhanced cognitive development (22, 25). Therefore, human milk is the ideal nutrient source for term and many preterm infants.

Except in the presence of rare genetic diseases, the clear advantage of human milk over any formula should lead to vigorous efforts by child care providers to promote and sustain breastfeeding for mothers who are willing to nurse their babies whenever they can and to pump and supply their milk to the child care facility when direct feeding from the breast is not possible. Even if infants receive formula during the child care day, some breastfeeding or expressed human milk from their mothers is beneficial (24).

Iron-fortified infant formula is the best next to human milk as a food for infant feeding. Supplementation with juice, cereal, and any other foods during the first 4 months of life is unnecessary and, for healthy infants, inappropriate. An adequately nourished infant is more likely to achieve normal physical and mental development, which will have long-term positive consequences on health (7, 8).

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### STANDARD 4.012
### INTRODUCTION OF SOLID FOODS TO INFANTS

In consultation with the child's parent and health care provider, solid foods shall be introduced routinely at no sooner than 6 months of age, as indicated by an individual child's nutritional and developmental needs. Introduction of solids and fruit juices for breastfed infants shall be started at six months of age unless the parent or health provider specifically recommends otherwise. Modification of basic food patterns shall be provided in writing by the child's health care provider.

RATIONALE: Early introduction (prior to 6 months of age) of solid food interferes with the intake of human milk or iron-fortified formula that the infant needs for growth. Solid food given before an infant is

developmentally ready may be associated with allergies and digestive problems. For breastfed infants, gradual introduction of iron-fortified foods should occur after 6 months, during which time these foods will complement the human milk. After 4 to 6 months of age, breastfed infants may require an additional source of iron in their diets. Infants who are not exclusively fed human milk should consume iron-fortified formula as the substitute for human milk. Infants on iron-fortified formula have an 8% risk for iron deficiency. Those exclusively breastfed have a 20% risk of iron deficiency by 9 to 12 months of age, and those consuming non fortified formula or whole cow's milk have the a 30% to 40% risk of iron deficiency by 9 to 12 months of age. In the United States, major non milk sources of iron in the infant diet are iron-fortified cereal and meats (8).

The transitional phase of feeding which occurs around 6 months of age is a critical time of development of fine, gross, and oral motor skills. When an infant is able to open her/his mouth, lean forward in anticipation of food offered, close the lips around a spoon, and transfer from front of the tongue to the back and swallow, he/she is ready to eat semi-solid foods.The process of learning a more mature style of eating begins because of physical growth occurring concurrently with social, cultural, sociological, and physiolo-gical development. Failure to introduce non-liquid food after 6 months of age may result in difficulties in introducing solid foods later. Variations in readiness for solid foods are common. While this standard states that the introduction of solids should start no sooner than 6 months of age for most infants, caregivers should be prepared to respond to a health care provider's recommendation for introduction of solids as early as 4 months of age for some infants.

Dental decay is transmissible. Bacteria which contri-bute to dental decay can be transmitted from caregivers to infants. Individuals with active tooth decay are more likely to transmit this bacteria to the children in their care.

COMMENTS: Early introduction of solids and fruit juices can interfere with breastfeeding or formula feeding. Many infants find juices appealing and may be satisfied by the calories in solids so they subsequently drink less human milk or formula (15). When juice is introduced, it should be by cup rather than bottle to decrease the occurrence of dental caries. Infants do not need juice unless their stools become hard from under-hydration or introduction of solids.

Although many people believe that infants sleep better when they start to eat solids, research reported in 1998 shows that longer sleeping periods are developmentally and not nutritionally determined in mid-infancy (8, 9).

A full daily allowance of Vitamin C is found in human milk (25). Most breastfed infants do not require supplemental vitamins. The AAP recommends Vitamin D supplementation for selected groups of infants whose mothers may be Vitamin D deficient or those infants who are not exposed to adequate sunlight (8, 18).

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

**STANDARD 4.013**

**FEEDING INFANTS ON DEMAND WITH FEEDING BY A CONSISTENT CAREGIVER**

Caregivers shall feed infants on demand unless the parent and the child's health care provider gives written instructions otherwise. Whenever possible, the same caregiver shall feed a specific infant for most of that infant's feedings.

RATIONALE: Demand feeding meets the infant's nutritional and emotional needs and provides an immediate response to the infant, which helps ensure trust and feelings of security.

When the same caregiver regularly works with a particular child, that caregiver is more likely to understand that child's cues and to respond appropriately.

COMMENTS: Caregivers should be gentle, patient, sensitive, and reassuring by responding appropriately to the infant's feeding cues. Cues such as opening the mouth, making suckling sounds, and moving the hands at random all send information from an infant to a caregiver. Early relationships between an infant and caregivers involving feeding set the stage for an infant to develop eating patterns for life.

Waiting for an infant to cry to indicate hunger is not necessary or desirable. Nevertheless, feeding children who are alert and interested in interpersonal interaction, but who are not showing signs of hunger, is not appropriate. Cues for hunger or interaction-seeking may vary widely in different infants.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

**STANDARD 4.014**
**TECHNIQUES FOR BOTTLE FEEDING**

When bottle feeding, caregivers shall either hold infants or feed them sitting up. Infants who are unable to sit shall always be held for bottle feeding.
The facility shall not permit infants to have bottles in the crib or to carry bottles with them either during the day or at night.

A caregiver shall not bottle feed more than one infant at a time.

RATIONALE: The manner in which food is given to infants is conducive to the development of sound eating habits for life. Caregivers should promote proper oral hygiene and feeding practices including proper use of the bottle for all infants and toddlers. Bottle propping can cause choking and aspiration and may contribute to long-term health issues, including ear infections (otitis media), orthodontic problems, speech disorders, and psychological problems (8, 14, 18, 22, 26, 27).

Any liquid except plain water can cause early childhood dental caries (8, 14, 18, 22, 26, 27). Early childhood dental caries in primary teeth may hold significant short-term and long-term implications for the child's health (8, 14, 18, 22, 26, 27).

Children are at an increased risk for injury when they walk around with bottle nipples in their mouths. Glass bottles create a safety hazard if the bottle is dropped and broken. Bacteria introduced by saliva makes milk consumed over a period of more than an hour unsuitable and unsafe for consumption. For safety and sanitary reasons, bottles should not be allowed in the crib or bed, whether propped or not.

It is difficult for a caregiver to be aware of and respond to infant feeding cues when feeding more than one infant at a time.

COMMENTS: Caregivers and parents need to understand the relationship between dental caries and the milk or juice in a bottle used as a pacifier.

Caregivers should offer children fluids from a cup as soon as they are developmentally ready. Children may be able to drink from a sippy cup as early as 5 months of age while for others it is later. Weaning a child to drink from a cup is an individual process, which occurs over a wide range of time. The American Academy of Pediatric Dentistry (AAPD) recommends weaning by the child's first birthday.

Use of a bottle or cup in an effort to modify a child's behavior should not be allowed (8, 28).

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

**STANDARD 4.015**
**FEEDING HUMAN MILK**

Expressed human milk shall be placed in a clean and sanitary bottle and nipple that fits tightly to prevent spilling during transport to home or facility. The bottle shall be properly labeled with the infant's name.

The bottle shall immediately be stored in the refrigerator on arrival. Expressed human milk shall be discarded if it presents a threat to a baby such as:
· Human milk is in an unsanitary bottle;
· Human milk that has been unrefrigerated for an hour or more;
· A bottle of human milk that has been fed over a period that exceeds an hour from the beginning of the feeding.

RATIONALE: This standard promotes the family's choice and practice of feeding human milk which is familiar to the infant. Child care providers should support and encourage this method of infant feeding because it is best for the infant.

Though human milk has antibacterial components, the bacterial load and the antibacterial component in any individual sample of human milk is unknown. When the infant feeds, the milk is inoculated by the infant's saliva and the bacteria in the infant's mouth. If the infant eats expressed milk from a bottle for periods in excess of an hour, bacteria could overwhelm the antibacterial components in the milk.

COMMENTS: The intent of this standard is to promote, support, and advocate feeding human milk by a mother because of the overwhelming benefits of human milk for infants. Using caution, providers can safely and properly store expressed human milk transported to the child care facility.

Chilled or frozen human milk may be transported from home to the child care facility in a cooler bag as long as the ambient temperature is below 86 degrees F and the out-of-refrigerator time is less than 2 hours.
See STANDARD 3.027 and STANDARD 6.035 for accidental feeding of human milk to another mother's child.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

**STANDARD 4.016**
**PREPARING INFANT FORMULA**

Formula provided by parents or by the facility shall come in a factory-sealed container. The formula shall be of the same brand that is served at home and shall be of ready-to-feed strength or prepared according to the manufacturer's instructions, using water from a source approved by the health department.

Formula mixed with cereal, fruit juice, or any other foods shall not be served unless the child's source of health care provides written documentation that the child has a medical reason for this type of feeding.

RATIONALE: This standard promotes the feeding of a formula familiar to the infant and supports family feeding practice. By following this standard, the staff is able, when necessary, to prepare formula and feed an infant safely, thereby reducing the risk of inaccuracy or feeding the infant unsanitary formula. Written guidance for both staff and parents must be available to determine when formula provided by parents will not be served as described in the standard above about unsanitary and unsafe formula. If a child has a special health problem, such as reflux, or inability to take in nutrients because of delayed development of feeding skills, the child's health professional should provide a written plan for the staff to follow so that the child is fed appropriately.

COMMENTS: The intent of this standard is to protect a child's health by reducing the risk of unsanitary and unsafe conditions of transporting infant formula prepared at home and brought to the facility.

To make infant formula bottles, the facility does not have to keep more than one container of the same brand and type of formula open at the same time. Parents can contribute their child's share of the formula or a share of the cost for a brand of formula the facility feeds to more than one infant. The bottles must be sanitary, properly prepared and stored, and must be the same brand in child care and at home.

In many communities, the sanitation standard for community water is high enough that tap water could be used, but this may vary from time to time and from community to community. Unless local health authorities recommend otherwise, water should be brought to a rolling boil before being used to make formula from concentrate or powder.

A safe source of water (usually tap water that is prepared fresh daily by being brought to a rolling boil) can be kept at room temperature. This water can be used by adding powdered formula to a bottle of water just before feeding (8, 18, 28). Bottles made in this way from powdered formula do not require refrigeration or warming and are promptly ready for feeding. The caregiver can make up whatever amount the infant seems to need at the time. Staff preparing formula shall thoroughly wash their hands prior to beginning preparation of infant feedings of any type.

Powdered formula is the least expensive type of formula. Providers shall only use the scoop that comes with the can and not interchange the scoop from one product to another, since the volume of the scoop may vary from manufacturer to manufacturer and product to product. Although many infant formulas are made from powder, the liquid preparations are diluted with water at the factory. Concentrated infant formula, not ready-to feed, must be diluted with water. Sealed, ready-to-feed bottles are easy to use also, but they are the most expensive approach to feeding formula.

Although some children have a medical indication for alternative feeding practices, feeding of solids and fruit beverages in the bottle to the child is often associated with premature feeding of these foods (when the infant is not developmentally ready for them) (8, 10, 16, 18, 25).

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

**STANDARD 4.017**

**PREPARATION AND HANDLING OF BOTTLE FEEDING**

Only cleaned and sanitized bottles, or their equi-valent, and nipples shall be used. All filled containers of human milk shall be of the ready-to-feed type, identified with a label which won't come off in water or handling, bearing the date of collection and child's full name. The filled, labeled containers of human milk shall be kept frozen or refrigerated, and iron-fortified formula shall be refrigerated until immediately before feeding. Any contents remaining after a feeding shall be discarded. Prepared bottles of formula from powder or concentrate or ready-to-feed formula shall be labeled with the child's name and date of preparation, kept refrigerated, and shall be discarded after 48 hours if not used. An open container of ready-to-feed or concentrated formula shall be covered, refrigerated, and discarded after 48 hours if not used.

Unused expressed human milk shall be discarded after 48 hours if refrigerated, or by three months if frozen, and stored in a deep freezer at 0 degrees F. Unused frozen human milk which has been thawed in the refrigerator shall be used within 24 hours. Frozen human milk shall be thawed under running cold water or in the refrigerator.

Human milk from a mother shall be used only with that mother's own child.

A bottle that has been fed over a period that exceeds an hour from the beginning of the feeding or has been unrefrigerated an hour or more shall not be served to an infant.

RATIONALE: Identification of the bottles prevents the potential for cross-infection when the facility is caring for more than one bottle-fed infant (2, 8). Placing human milk in ready-to-feed bottles (including single-use bags in a plastic holder) decreases the potential for exposure and spills. Infants should not be fed a formula different from the one the parents feed at home or human milk intended for another infant, as even minor differences in formula and the specific components of human milk can cause gastrointestinal upsets and other problems (54).

Bottled formula that has been fed should not be reused because the formula will have been contaminated with saliva and bacteria, which could multiply to spoil the formula before the bottle is refed. This is especially true if the bottle is out of refrigeration for the first feeding for an hour or more and then reheated. Open containers of powdered formula are not safe to use beyond the stated shelf period (8). It is difficult to maintain 0 degrees F consistently in a freezer compartment of a refrigerator or freezer, so caregivers should carefully monitor temperature of freezers used to store human milk using an appropriate working thermometer. Human milk contains components that are damaged by excessive heating during or after thawing from the frozen state (54).

Labels for containers of human milk should be resistant to loss of the name and date when washing and handling.This is especially important when the frozen bottle is thawed in running tap water. There may be several bottles from different mothers being thawed and warmed at the same time in the same place. Frozen milk should never be thawed in a microwave oven.

COMMENTS: See STANDARD 4.018, regarding bottle warming and microwave ovens. STANDARD 3.027 regarding accidental feeding of human milk to another mother's child.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Hom*e

**STANDARD 4.018**

**WARMING BOTTLES AND INFANT FOODS**

Bottles and infant foods shall be warmed under running warm tap water or by placing them in a container of water that is no warmer than 120 degrees F Bottles shall not be left in a pot of water to warm for more than 5 minutes. Bottles and infant foods shall not be warmed in a microwave oven. After warming, bottles shall be mixed gently and the temperature of the milk tested before feeding. Infant foods shall be stirred carefully to distribute the heat evenly. A caregiver shall not hold an infant while removing a bottle or infant food from the container of warm water or while preparing a bottle or stirring infant food that has been warmed in some other way.

If a slow-cooking device, such as a crock pot, is used for warming infant formula, human milk, or infant food, this slow-cooking device shall be out of children's reach, shall contain water at a temperature that does not exceed 120 degrees F. and shall be emptied, sanitized, and refilled with fresh water daily.

RATIONALE: Bottles of formula or human milk that are warmed at room temperature or in warm water for an extended time provide an ideal medium for bacteria to grow. Infants have received burns from hot water dripping from an infant bottle that was removed from a crock pot or by pulling the crock pot down on themselves by a dangling cord. Caution should be exercised to avoid raising the water above a safe level for warming infant formula or infant food. Studies have documented the dangers of using microwave ovens for heating human milk, formula, or food to be fed to infants (29, 55).

Excessive shaking of human milk may damage some of the cellular components that are valuable to the infant, as may excessive heating. Excessive shaking of formula may cause foaming that increases the likelihood of feeding air to the infant.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Hom*e

**STANDARD 4.019**

**CLEANING AND SANITIZING EQUIPMENT USED FOR BOTTLE FEEDING**

Bottles, bottle caps, nipples and other equipment used for bottle feeding shall not be reused without first being cleaned and sanitized by washing in a dishwasher or by washing, rinsing and boiling for one minute.

RATIONALE: Infant feeding bottles are contaminated by the child's saliva during feeding. Formula and milk promote growth of bacteria. To avoid contamination of subsequent feedings, bottles, bottle caps, and nipples that are reused should be washed and sanitized.

COMMENTS: Excessive boiling of latex bottle nipples will damage them.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

**STANDARD 4.020**
**FEEDING COW'S MILK**

The facility shall not serve any cow's milk to infants from birth to 12 months of age and shall serve only whole, pasteurized milk to children between 12 and 24 months of age who are not on formula or human milk. The facility shall not serve skim milk, reconstituted nonfat dry milk, or milk containing 1% or 2% butterfat to any child between 12 and 24 months of age, except with the written direction of a parent and the child's health care provider.

RATIONALE: Low-fat milk does not provide enough calories and nutrients for children from 1 to 2 years of age. If a child seems to be gaining weight excessively, he or she should be referred to the primary health care provider. The American Academy of Pediatrics recommends that whole cow's milk not be used during the first year of life (7, 8, 18, 28, 53).

COMMENTS: This standard is consistent with the recommendation of the American Academy of Pediatrics for feeding children to 2 years of age, when brain development requires a certain amount of fat in the diet. Although obesity can be a problem, it can be controlled by volume of intake and balance with other desirable foods instead of reducing the fat content of milk in children younger than 2 years of age.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

**STANDARD 4.021**
**FEEDING SOLID FOODS TO INFANTS**

Staff members shall serve commercially packaged baby food from a dish, not directly from a factory-sealed container. They shall serve solid food by spoon only. They shall discard uneaten food in dishes from which they have fed a child. The facility shall wash off all jars of baby food with soap and warm water before opening the jars, and examine the food carefully when removing it from the jar to make sure there are not glass pieces or foreign objects in the food.

Food shall not be shared among children using the same dish or spoon. Unused portions in opened factory-sealed baby food containers or food brought in containers prepared at home shall be stored in the refrigerator and discarded if not consumed after 24 hours of storage. Solid food shall not be fed in a bottle or in an infant feeder unless the child has specific written instructions from a health professional to do so.

RATIONALE: The external surface of a commercial container may be contaminated with disease-causing microorganisms during shipment or storage and may contaminate the food product during feeding. A dish should be cleaned and sanitized before use, thereby reducing the likelihood of surface contamination. Any food brought from home should not be served to other children. This will prevent cross-contamination and reinforce the policy that food sent to the facility is for the designated child only.

Uneaten food should not be put back into its original container for storage because it may contain potentially harmful bacteria from the infant's saliva. Solid food should not be fed in a bottle or an infant feeder apparatus because of the potential for choking. In addition, this method teaches the infant to eat solid foods incorrectly.

COMMENTS: For additional information on nutrition for infants, seeSTANDARD 8.036. See also STANDARD 4.038, on the size of food pieces to serve infants, and STANDARD 4.035 and STANDARD 4.036, on supervision of feeding.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

**9.**

**From: Seattle-King County CCHP Health Policy Templates**

## INFANT BOTTLE FEEDING

- Infants are fed breastmilk or iron-fortified infant formula until they are one year old.
- Written permission from the child's licensed health care provider is required if an infant is to be fed an electrolyte solution *(e.g., Pedialyte®)* or a special diet formula.
- No medication, cereal, supplements, or sweeteners are added to breastmilk or formula without written permission from the child's licensed health care provider.
- Bottles contain formula or breastmilk. Juice, if offered, is served only in a cup.
- Cups of water, formula or breastmilk are introduced around 6 months of age.

### Storage

1. All bottles are labeled with infant's **full name and date**.
2. Filled bottles are capped and refrigerated upon arrival or after being mixed, unless being fed to an infant immediately.
2. Bottles are stored in the coldest part of the refrigerator, not in the refrigerator door.
3. A thermometer is kept in the warmest part of the refrigerator (usually the door) and is at or below 41° F at all times. *(It is recommended that the refrigerator be adjusted between 30° and 35° to allow for a slight rise when opening and closing the door.)*
4. Frozen breastmilk is stored at 10° F or less and for no longer than 2 weeks. Containers of breastmilk are labeled with the child's full name and date. Unused, thawed breastmilk is returned to the family at the end of the day.

### Bottle Preparation

□ We ask families to bring bottles already prepared.

□ We prepare bottles on site:

- A minimum of eight feet is maintained between the food preparation area and the diapering area. *(If this is not possible, a moisture-proof, transparent 24-inch high barrier – such as Plexiglas - must be installed.)*
- Preparation surfaces are cleaned, rinsed, and sanitized before bottles are prepared.
- Staff wash hands in the handwashing sink before preparing bottles. The food preparation sink is not used for handwashing or general cleaning.
- Frozen breastmilk is thawed in the refrigerator or in warm water (water under 120° F) and then warmed as needed before feeding. Thawed breastmilk is not refrozen.

- Bottles of formula are prepared with cold water from the following clean source: _____.

  Water from a handwashing sink is **not** used for bottle preparation.

  *(Hot tap water can be contaminated with lead. Only cold water should be taken from the tap for cooking or drinking.)*
- Formula cans are dated when opened and used within 30 days.
- Formula is mixed as directed on the can and not used past expiration date.
- Gloves are worn when scooping powdered formula from a can. Gloves used for food preparation are kept in food preparation area.
- Bottles are labeled with infant's full name and date. Bottles are capped and refrigerated if not immediately used. Bottle nipples are covered at all times, except during feeding, to reduce the risk of contamination and exposure.

**Bottle Warming**

1. Bottles are **not** warmed in a microwave.
2. Bottles are warmed using the following method:
   □ We place bottles in warm water (<120°F).
   □ We use a bottle warmer.
   - Bottle warmer is secured to the counter or wall.
   - Bottle warmer is cleaned, rinsed, and sanitized daily.

   □ We use a crock pot *(<u>not recommended</u>)*, and
   - Water temperature in crock pot is monitored and kept below 120°F.
   - Crock pot **contains no more than 1 1/2 inches** of water. *(Crock pots pose a risk of scalding.)*
   - Crock pot is secured to the counter or wall.
   - Crock pot is cleaned, rinsed, and sanitized daily.

   □ Other: _____
   _____.
3. Bottles are warmed no longer than 5 minutes.
4. Temperature is checked before bottle is fed to infant (wrist method).

**Bottle Feeding**

1. Infants are fed on demand. Staff watch for and respond appropriately to hunger cues such as:
   ▪ fussiness/crying ▪ opening mouth as if searching for a bottle/breast
   ▪ hands to mouth and turning to caregiver ▪hands clenched
2. Bottles are labeled with time feeding begins.

3. The name on each bottle is checked before the bottle is offered to an infant.
4. During bottle feeding, infants are held by a caregiver who makes eye contact with the infant and talks to and touches the infant in a nurturing way. Bottles are not propped.
5. Older infants who can sit and hold a bottle independently are either held or placed in a high chair or chair that allows the feet to touch the floor at an appropriately-sized table.
6. **Infants are not allowed to walk around with bottles and are never given a bottle while lying down or in a crib.** *(Lying down with a bottle puts a baby at risk for baby bottle tooth decay, ear infections, and choking.)*
7. Staff watch for and respond appropriately to fullness cues such as:

   ▪falling asleep ▪decreased sucking ▪arms and hands relaxed

   ▪pulling or pushing away
8. Unconsumed bottles are dumped into a sink after 1 hour to prevent bacterial growth.

**Bottle Cleaning**

Used bottles and dishes are not stored within eight feet of the diapering area or placed in the diapering sink.

□ Bottles are not re-used at our center. Families provide a sufficient number of bottles to meet the daily needs of the infant.

□ We re-use bottles during the day (or from day to day without sending them home). Between uses, bottles, bottle caps, and nipples are placed in a tub for dirty dishes (or directly into dishwasher), then

- □ Washed in dishwasher.
- □ Washed, rinsed, and boiled for one minute.

## INFANT AND TODDLER SOLID FOODS

1. Food is introduced to infants when they are developmentally ready for pureed, semi-solid and solid foods. Food, other than formula or breastmilk, is not given to infants younger than 4 months of age, unless there is a written order by a health care provider.
2. No egg whites *(allergy risk)* or honey *(botulism risk)* is given to children less than 12 months of age. (This includes other foods containing these ingredients such as honey graham crackers.)
3. Cups and spoons are encouraged at mealtime by 9 months of age.
4. Chopped, soft table foods are encouraged after 10 months of age.
5. Children 12-23 months are given whole milk, unless the child's parent/guardian ***and*** health care provider have requested low-fat milk or a non-dairy milk substitute in writing. *(Low-fat diets for children under age 2 may affect brain development.)*

6. When parents provide food from home, it is labeled with the child's name and the date. Perishable foods are stored at or below 41° F.
7. Before food is prepared, preparation surfaces are cleaned, rinsed, and sanitized.
8. Staff wash hands in the handwashing sink before preparing food. The food preparation sink is not used for handwashing or general cleaning.
9. Staff serve commercially packaged baby food from a dish, not from the container. Foods from opened containers are discarded or sent home at the end of the day.
10. Gloves are worn or utensils are used for direct contact with food. *(No bare hand contact with ready-to-eat food is allowed.)* Gloves used for food preparation are kept in food preparation area.
11. Children eat from plates and utensils. Food is not placed directly on table.
12. Children are not allowed to walk around with food or cups.
13. Teachers sit with infants and young children when eating and engage in positive social interaction.

*For allergies or special diets, see the NUTRITION section of this policy.*

***10.***

## *[State of Colorado]* GUIDELINES FOR THE USE OF SANITIZERS AND DISINFECTANTS IN CHILD CARE CENTERS

These general guidelines for applying the *Rules and Regulations Governing the Sanitation of Child Care Centers in the State of Colorado* are provided by the Colorado Department of Public Health and Environment, Consumer Protection Division. Additional information about the rules and regulations may be obtained by calling 303-692-3620, or visiting the division's web page at www.cdphe.state.co.us/cp/

## HOW DO SANITIZERS DIFFER FROM DISINFECTANTS?

All chemical sanitizing agents used in child care centers **must** be registered with the U. S. Environmental Protection Agency (EPA). The EPA registration number will be listed on the product's label, along with the manufacturer's claims (i.e., "kills germs such as E. coli.," etc.)

The EPA classifies these products based on the number and stringency of tests they are required to pass. *Sanitizers* reduce the number of bacteria in one test by 99.99%. There are two types of sanitizers – those used on food contact surfaces and those used on non-food contact surfaces. *Disinfectants* must be shown to be effective against 99.99% of bacteria in multiple tests. Disinfectants are further classified into three categories, depending on effectiveness: limited efficacy, general efficacy and hospital disinfectant.

In general, sanitizers are used on surfaces that require a reduction of microorganisms to levels considered safe. Sanitizers are most appropriate for use on surfaces that have not been contaminated with bodily secretions or excretions. Disinfectants should be used on hard surfaces to destroy infectious bacteria and fungi and *hospital disinfectants* must be used on surfaces contaminated with bodily secretions and excretions.

## BLEACH – THE MOST COMMONLY USED SANITIZER/DISINFECTANT

The most commonly used chemical sanitizing agent is **sodium hypochlorite** (chlorine bleach). Bleach can be used to sanitize or disinfect, depending on the concentration. The required concentration of bleach depends upon the surface that is being sanitized or disinfected:

- Diapering areas and equipment touched during diapering ¼ cup/gal. of water
- Surfaces likely to be contaminated with bodily secretions/excretions ¼ cup/gal. of water
- Food contact surfaces 50 – 200 ppm
- Surfaces that are not contaminated with bodily secretions/excretions 50 – 200 ppm

## HOW DOES ONE KNOW IF A PRODUCT IS APPROVED?

There are a number of other chemical sanitizing agents approved for use in child care centers. One example is quarternary ammonia. To evaluate the use of a particular product, follow these guidelines:

**For diapering areas or other surfaces contaminated with bodily secretions or excretions**, the product is approved if:

- It is registered with the EPA as a hospital disinfectant and provides the equivalent bactericidal and viricidal effect of ¼ cup of bleach per gallon of water and;
- It is used according to the manufacturer's instructions, including concentration and contact time.
- Products registered as hospital disinfectants will usually have label information indicating effectiveness against *Salmonella choleraesuis, Staphylococcus aureus* and *Pseudomonas aeruginosa*. (EPA requires that hospital disinfectants be tested for efficacy against these three organisms.)

For **food contact surfaces**, the product is approved if:

- It is registered with the EPA and;
- It is labeled for use on food contact surfaces and;
- It is used according to the label instructions, including concentration and contact time and;

The product is allowed under Sanitizers, 21 CFR 178.1010. (see appendix G of the *Colorado Retail Food Establishment Rules and Regulations*.)

For other **surfaces not contaminated with bodily secretions or excretions**, the product is approved if:

- It is registered with the EPA and;
- It is used according to the label instructions, including concentration and contact time.

**Toys that are mouthed** but not contaminated with bodily excretions may be sanitized in a manner similar to that used for food contact surfaces.

## USE AND STORAGE OF SANITIZERS

Bleach solutions used in the diapering areas may be stored in a spray bottle and should be changed as often as is necessary to maintain the required concentration. Bleach solutions that become contaminated with organic material or that are stored in open containers must be changed more frequently. Test kits should be used to verify the concentration of the solution. The solution should be in a labeled container and kept completely out of the reach of children.

Surfaces should be cleaned prior to applying any sanitizer or disinfectant, and all chemical agents must be allowed to remain in contact with the surface for the contact time specified on the product's label.

## ADDITIONAL INFORMATION AND GUIDANCE

All sanitizers and disinfectants must be used in a manner consistent with their labeling. If, after reading a label, you question its use, please do not hesitate to contact the Consumer Protection Division, Institutional Environmental Health Program at 303-692-3620. Guidance is also available from the National Antimicrobial Information Network at 1-800-447-6349, through e-mail at nain@ace.orst.edu or from the National Pesticide Telecommunications Network at 1-800-858-7378.

## 11.
## Notes from: Mark Kastenbaum, DEL Health Specialist, Southwest Service Area

Both briefing papers enclosed [Septic systems and Water] have been revised many times and address the majority of Public Health questions dealing with sewers and septic systems. The WSCHSA Committee has been quite inclusive and allowed input from various stakeholders, including Health Specialists. The issue papers deal with family homes and child care centers. I included [Colorado] guidelines concerning sanitizers and of course please refer to Caring For Our Children, National Health and Safety Performance Standards: Appendix I, (pp.417-418)

[Bleach:]
Many local health jurisdictions recommend ¼ teaspoon + 1 quart of cool water for food contact surfaces or 1 teaspoon liquid bleach per gallon of cool water. Family Home WAC 170-296-1000 (3) supports this. We (Health Specialist) use chlorine dip paper to measure the available concentration of bleach solution. The dip paper is compared to a color chart to measure the parts per million (ppm) of available chlorine. The temperature, Ph and hardness of the water may have a direct effect on the sanitizer. In theory, two different water sources may have a different ppm range when using the same recipe.

*[Mark provided the same Septic and Water briefing papers provided by Snohomish County Health District – see attachments 2 and 3; as well as the Colorado guidelines on sanitizers – see attachment 10 - enclosed in these NRMT meeting notes.]*

***12.*** Additional materials responding to NRMT questions: See the attached Adobe file: "AdditionalHealthMaterialsReNRMTQuestions.pdf"

e. Storing breast milk (information advertisement from the Women, Infants and Children [WIC] nutrition program)

f. Heating formula (June 20, 2008 e-mail from Mead Johnson Nutritional to Elaine Ruhlman RN)

g. *A Child Care Provider's Guide to Safe Slee*p (from the American Academy of Pediatrics, undated)

h. Are BPA plastic's claims shatterproof? (Seattle Times article, May 19, 2008 regarding plastic contains containing bisphenol A plastic)